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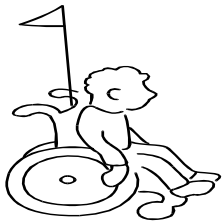
MISSION STATEMENT

Children's Special Health Care Services Program

The mission of the Children's Special Health Care Services (CSHCS) program is to help the families of participants with serious, chronic medical conditions obtain medical treatment related to the participant's medical condition. The CSHCS program seeks to help individuals from birth to 21 years of age (with the exception of Cystic Fibrosis participants who may be on the program for life), who meet the program's financial and medical criteria. The program seeks to assist with severe chronic medical conditions that have lasted (or may be expected to last) at least two years; produce disability and disfigurement; limitations on the participant's ability to function; and, without treatment would produce a chronic disabling physical condition.



Dear CSHCS Participant:

Welcome to the Children's Special Health Care Services (CSHCS) program. This revised manual is being issued to help you understand the services provided by the program. It is your responsibility to become familiar with CSHCS policies if you want to be sure a service is covered.

In addition to the participant's manual you are also receiving a CSHCS participant card. The card lists the participant's name, date of birth, key number, the effective date and the CSHCS 800 number and TTY number. Please review the card and make sure the information is correct as the card serves as documentation of enrollment on the CSHCS program. Remember to present your participant card at your doctor's office or pharmacy wherever you receive health care services. If you have any questions or you do not understand something please call the CSHCS program at **1/800-475-1355 or the TTY number at 1/866-275-1274**.

The CSHCS program looks forward to working with you.

Sincerely,

Children's Special Health Care Services

TERMS AND DEFINITIONS

Basic Dental Care	Basic routine dental care (e.g., cleanings, fillings, x-rays). This dentist or provider must be enrolled in the CSHCS provider program.
Eligible Medical Condition	The diagnosis for which you were approved for the CSHCS program (e.g., asthma, congenital heart defect, cerebral palsy, etc.).
Exclusions	Those items or services not covered by the CSHCS program.
Explanation of Benefits (EOB)	A form submitted to CSHCS from the service provider after the insurance company has processed a claim.
Out of State Care	Treatment received outside of the State of Indiana. Must have a prior authorization.
Participant	The client or the parent/guardian of the client on the CSHCS program.
Primary Care Provider	The doctor who is seen for routine health care (e.g., colds, immunizations, etc.). This physician or provider must be enrolled in the CSHCS provider program.
Prior Authorization (PA)	A statement that services are related to the eligible medical condition. CSHCS will pay the provider after insurance has been billed. Payment for authorized services will be made only if all CSHCS policies are met.
Specialized Dental Care	Specialized dental services needed to treat an eligible medical diagnosis such as cleft lip and palate. Must have a prior authorization (PA) before dental work begins.
Specialty Care Provider	The doctor who provides care related to the **eligible medical condition**. This physician or provider must be enrolled in the CSHCS provider program.

You Need To Know

The Children's Special Health Care Services program is the payer of last resort. This means that your primary insurance or Hoosier HealthWise/Medicaid must always be billed first before billing the CSHCS program.

Before making your first appointment with any provider please contact the provider to see if he/she is enrolled in the program and then call the CSHCS **Prior Authorization (PA) Unit at 1/800-475-1355 or TYY number 1/866-275-1274.** Before CSHCS will assist with any medical bills, your providers must be enrolled as CSHCS providers and **all services must be prior authorized**.

The provider you select must be a CSHCS provider. If the provider you select is not a CSHCS provider, contact the CSHCS Claims Unit. They will contact your preferred provider to see if he/she is willing to enroll in the program. If you choose to stay with a provider who declines to become a CSHCS provider, **you will be responsible for the bills.**

If your doctor agrees to become a CSHCS provider, there must be a signed provider agreement with the CSHCS program. Specialty care services must be related to the participant's eligible medical condition and must have prior approval from the program before those services are obtained and before reimbursement is made to the provider(s).

All services processed and paid by CSHCS are based on Indiana Medicaid allowed rates. This means that the program may not pay the full amount that your provider bills. If CSHCS approves the charge for services, you should not be billed for any balance.

Services Provided

The CSHCS program operates as a limited supplemental health insurance policy for enrolled participants. The program may pay for medical services only after other health insurance (private or public—Hoosier HealthWise and Medicaid) has paid or denied coverage. The CSHCS program **may** pay for:

- Primary Care Visits—any sick or well-participant visits to a primary care physician or provider in an office or clinic.
- Specialty Care Visits—health care visits made to a specialty care physician or provider for care related to the eligible medical diagnosis.
- Basic Preventive Dental Care Visits—any visit to a dentist or dental health provider for routine or basic dental care as defined by the program.
- Specialized Dental Care Services—dental service needed to treat the eligible medical condition such as cleft lip or palate.
- Pharmacy Services – prescriptions for medications prescribed by your physician that are necessary for treatment. Over the counter items are not usually covered even if the doctor writes a prescription. All of these items need prior authorization.

Listed below are definitions of the various types of providers:

- A **primary care provider** is the doctor or clinic who sees the participant for regular visits (e.g., well participant physicals) and immunizations. He would also see the participant when sick (colds, flu, etc.). The CSHCS program may pay for office visits, lab work, x-rays or any prescription medications prescribed by the primary care provider.

- A **specialty care provider** is the doctor or clinic that sees the participant for treatment of his/her **eligible medical condition.** Sometimes the primary and specialty care doctors are the same. The CSHCS program may pay for office visits, lab work, x-rays or any prescription medications prescribed by the specialty care provider.

- A **dental care provider** is the dentist or clinic that sees the participant for the routine or basic dental care that keeps teeth healthy. Some services covered for routine dental care include: examinations, prophylaxis (cleanings) and fluoride treatments every six (6) months, sealants, x-rays, fillings and some stainless steel crowns.

Prior Authorization

A prior authorization (PA) is a statement that services are related to the eligible medical condition. Payment for authorized services will be made only if all CSHCS policies are met. Prior authorization is another way of saying "ask before obtaining services". **If you do not ask first or obtain a prior authorization, your bills may not be paid.**

A prior authorization is needed for most of the services the participant may require. Some PA's will be written once and will be valid for as long as the participant is on the program. Others may be written for a short period of time or for one time only depending on the type of services the participant is requesting. **If you don't request a prior authorization before obtaining services, the resulting bills will be the responsibility of the participant**. Below is a list of some services that require a PA. **Remember, if in doubt about whether or not a service is covered, call the CSHCS program 800 number**.

- Inpatient services (hospitalizations)
- Equipment and supplies
- Surgery
- Specialized dental care
- Therapy (occupational, physical, speech)
- Home health care items
- Primary care
- Specialty care
- Basic dental care
- **Emergency room services** - the participant **must notify** the CSHCS program of **emergency care** and hospitalizations within five (5) working days of the visit. When counting the notification period do not include Saturdays, Sundays, or legal holidays. An authorization

for payment will be written only after the PA Unit receives the discharge summary or medical notes from the emergency room visit. The **participant is responsible** for seeing that these documents are mailed or faxed to the program. Only services related to the eligible medical condition(s) will be authorized.

Insurance

The CSHCS program is set up as a supplemental insurance company and therefore, will only pay after your insurance (private or Hoosier HealthWise/Medicaid) has been billed. **You must follow the rules for your primary insurance coverage**. To utilize CSHCS benefits, the participant must:

1. Learn about the benefits of your primary insurance company. CSHCS can not and will not override those rules. CSHCS will not pay for a service that the insurance company has denied because the participant did not follow the rules or the participant sought services outside their network.

2. Report all insurance changes immediately to providers and the CSHCS program. Failure to disclose insurance benefits may lead to the participant being denied further services from CSHCS.

3. Inform your providers to bill the primary insurance first. CSHCS should then be billed with an EOB (explanation of benefits) attached with the claim.

4. If the insurance requires a prior authorization for a service, it is the responsibility of the participant to get that PA before the service is rendered. If the insurance denies a service because the participant did not get prior authorization, CSHCS will also deny the claim and the bill will become the responsibility of the participant. Also, if you use a Health Maintenance Organization (HMO), a preferred provider organization (PPO) or a point of service (POS) as your provider, you will need to use the providers within those networks for obtaining medical care, hospitalizations, prescriptions and supplies. This also applies to Hoosier HealthWise/Medicaid providers.

5. You may be asked to appeal denials by your insurance company for services that should be covered. It may be that the insurance company requires more information. Please cooperate with any request made by your insurance company for further information.

6. CSHCS may cover all or part of the participant's deductible, co-payments (up to $25.00) or Medicaid "spend down" for the participant's physician, drug store, hospital or other health care providers.

Remember, it is important to seek services from CSHCS providers. These providers should not bill the participant for services rendered. CSHCS will only reimburse the providers and will not reimburse the participant for deductibles, co-payments or balances that the participant pays. **It is the responsibility of the participant to inform providers that bills must be sent to CSHCS within one (1) year of the date of the service**. There are exceptions, but without appropriate documentation CSHCS will not pay for claims submitted late. The participant will be responsible for the unpaid bill.

Exclusions (Services Not Covered)

There are some services, supplies, equipment and medications that CSHCS will not cover at all. Some of these items, called *exclusions* are listed below. **This list is not all inclusive, if you want to know if a specific item or service is covered, call the CSHCS 800 number.**

- Over-the-counter drugs (e.g., Tylenol, cough syrup, vitamins, etc.) even with a doctor's prescription.
- Over-the-counter supplies (diapers, non-sterile gloves, alcohol, tape, bleach, Band-Aids, etc).
- Mental health services, counseling, testing, therapy (except when prior authorized), and substance abuse treatment.
- Prenatal care or other pregnancy-related care.
- Emergency room visits for reasons not related to the participant's eligible diagnosis (e.g., if the eligible diagnosis is Asthma, the CSHCS program will not cover an emergency room visit for a broken arm).
- Hospitalization for reasons not related to the eligible diagnosis.
- Organ transplants
- Eyeglasses, if not related to the eligible diagnosis
- Earplugs
- Diapers
- Egg crate mattress covers, etc.
- Communication boards/devices

Participant's Responsibility

You must notify the program of:

- Address changes
- Change of phone number
- Changes of household income for members
- Changes in insurance coverage (change of company, Hoosier HealthWise/Medicaid, service coverage or termination)
- Parent/guardian name change as a result of marriage or divorce
- An enrolled participant's marriage
- An enrolled participant's emancipation (moves out on his/her own)
- Emergency room visits
- Hospital admission
- Need for prior authorization

What To Do If You Receive a Bill

If you receive a bill, never assume that sending you the bill was a mistake. Contact the provider immediately to see why you received the bill. Make sure that the provider knows to bill your insurance company or Hoosier HealthWise/Medicaid coverage first, and then the CSHCS program. Make sure that the provider has the correct mailing address for CSHCS:

ISDH/CSHCS - Claims
2 North Meridian, Section 7B
Indianapolis, IN 46204

If the provider says that the participant is responsible for the balance of a bill paid by CSHCS, contact the **Claims Unit** at 1-800-475-1355 immediately; however, CSHCS may not be able to help you if the bill goes to a collection agency. Services that have been denied by the CSHCS program will be the participant's responsibility.

Transportation and Travel

Families who can provide their own transportation or meet those costs without hardship are expected to do so. The CSHCS program does not provide transportation for participants. The cost of traveling to and from an appointment for the participant to see an approved CSHCS provider may be covered for mileage over 50 (fifty) miles round trip for **authorized services**. Mileage is calculated city-to-city based on the Indiana State Mileage chart and **not** on an odometer reading. The rate is paid per trip, (e.g., if your participant has an appointment in May and another appointment in June, the mileage for each trip would be covered).

Travel reimbursement (money paid back to you) will be made at the State of Indiana's rate, which is currently 28 cents per mile. An **authorized** out-of-state trip will pay 28 cents per mile for the first 500 miles and 14 cents per mile for the next 2,500 miles. The CSHCS program **will not reimburse** for transportation to see a hospitalized participant, parking, meals or lodging, etc.

Reimbursement checks will be mailed directly to you from the Finance Division of the Indiana State Department of Health. This process may take **several weeks** after the submission of the signed travel vouchers from the CSHCS program to the Finance Division. Properly signed and completed travel vouchers must be mailed to the CSHCS Indianapolis office (address listed on the participant's card) within one (1) year of the date of travel. For example, if you took your participant to a clinic on May 1, 2001 you must submit your travel vouchers by May 1, 2002). Travel voucher may be obtained by calling the CSHCS 800 number.

Re-Evaluations

Once a year, participants of the program are re-evaluated to determine if there have been changes in their eligibility status. The re-evaluation is required to maintain your active status on the program. All re-evaluations will be completed by mail.

During the re-evaluation you will be asked to update the program on your income status by submitting copies of your last three (3) consecutive pay stubs or by submitting other proof of income such as your latest tax form. Insurance information, household members and other changes in income or family will need to be updated and reviewed. Remember, even though you will have a yearly re-evaluation, whenever any information changes or needs to be updated, you are to call the CSHCS program.

When you receive notification of the re-evaluation, you must return the information requested as soon as possible. The date that the information needs to be returned to the CSHCS office will be

indicated when the re-evaluation form is sent to you. Failure to return the updated information could result in the closure of the case.

Case Closures

Case closures may occur for various reasons. Some of the reasons the participant's enrollment may be cancelled are:

- Failure to complete and return the annual re-evaluation form within the allotted time.
- Failure to provide updated income information.
- The participant has reached the age of 21 years.
- Failure to utilize health insurance

We look forward to helping you and your family. If you have any questions regarding the material contained within this manual please call the CSHCS 800 number.